

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6718

CERTIFICATE OF DEATH

06696

Reg. Dist. No. 351

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Worcester</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	LENGTH OF STAY (in this place) <i>81 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>William H. Grimes</i>		<i>June 21 1956</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
<i>male</i>	<i>white</i>	<i>married</i>	<i>Jan 10 - 1861</i>
9. AGE last birthday		10. IF UNDER 1 YEAR	
<i>93 5/11</i> yrs.		Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. BIRTHPLACE (State or foreign country)	
<i>trained farmer own farm</i>		<i>Berlin, Md</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>William C. Grimes</i>		<i>Nancy C. Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>no</i>		<i>none</i>	
17. INFORMANT & ADDRESS			
<i>Mrs. Winona Grimes Snow Hill</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A)		<i>Acute Pulmonary Edema</i>	
ANTECEDENT CAUSE(S) DUE TO		<i>Hypertensive Cardiovascular disease</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<i>Blind</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
20d. TIME OF INJURY (Month) (Day) (Year) (Hour)		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 18, 1956</i> , to <i>June 21, 1956</i> , that I last saw the deceased alive on <i>June 21, 1956</i> , and that death occurred at <i>2:50 P.M.</i> from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
<i>John L. M...</i>		<i>104 Bay St. Snow Hill, Md.</i>	
DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>June 24/56</i>		<i>Whitewater Cemetery Snow Hill, Md</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>md</i>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
<i>Elwyn Cooper</i>		<i>Elwyn Cooper, Snow Hill, Md</i>	
DATE		ADDRESS	
<i>JUN 25 1956</i>			

CERTIFICATE OF DEATH

Form No. 100-100

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. DATE OF DEATH

14. TIME OF DEATH

15. PLACE OF INTERMENT

16. NAME OF CEMETERY

17. NAME OF FUNERAL HOME

18. NAME OF NEXT OF KIN

19. ADDRESS OF NEXT OF KIN

20. TELEPHONE NUMBER

21. SIGNATURE OF DECEASED

22. SIGNATURE OF WITNESSES

23. SIGNATURE OF CLERK

24. SIGNATURE OF JUDGE

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF CORONER

27. SIGNATURE OF DISTRICT ATTORNEY

28. SIGNATURE OF COUNTY CLERK

29. SIGNATURE OF TOWNSHIP CLERK

30. SIGNATURE OF VILLAGE CLERK

31. SIGNATURE OF CITY CLERK

32. SIGNATURE OF STATE CLERK

33. SIGNATURE OF FEDERAL CLERK

34. SIGNATURE OF MARSHAL

35. SIGNATURE OF SHERIFF

36. SIGNATURE OF CORONER

37. SIGNATURE OF DISTRICT ATTORNEY

38. SIGNATURE OF COUNTY CLERK

39. SIGNATURE OF TOWNSHIP CLERK

40. SIGNATURE OF VILLAGE CLERK

41. SIGNATURE OF CITY CLERK

42. SIGNATURE OF STATE CLERK

43. SIGNATURE OF FEDERAL CLERK

44. SIGNATURE OF MARSHAL

45. SIGNATURE OF SHERIFF

46. SIGNATURE OF CORONER

47. SIGNATURE OF DISTRICT ATTORNEY

48. SIGNATURE OF COUNTY CLERK

49. SIGNATURE OF TOWNSHIP CLERK

50. SIGNATURE OF VILLAGE CLERK

51. SIGNATURE OF CITY CLERK

52. SIGNATURE OF STATE CLERK

53. SIGNATURE OF FEDERAL CLERK

54. SIGNATURE OF MARSHAL

55. SIGNATURE OF SHERIFF

56. SIGNATURE OF CORONER

57. SIGNATURE OF DISTRICT ATTORNEY

58. SIGNATURE OF COUNTY CLERK

59. SIGNATURE OF TOWNSHIP CLERK

60. SIGNATURE OF VILLAGE CLERK

61. SIGNATURE OF CITY CLERK

62. SIGNATURE OF STATE CLERK

63. SIGNATURE OF FEDERAL CLERK

64. SIGNATURE OF MARSHAL

65. SIGNATURE OF SHERIFF

66. SIGNATURE OF CORONER

67. SIGNATURE OF DISTRICT ATTORNEY

68. SIGNATURE OF COUNTY CLERK

69. SIGNATURE OF TOWNSHIP CLERK

70. SIGNATURE OF VILLAGE CLERK

71. SIGNATURE OF CITY CLERK

72. SIGNATURE OF STATE CLERK

73. SIGNATURE OF FEDERAL CLERK

74. SIGNATURE OF MARSHAL

75. SIGNATURE OF SHERIFF

76. SIGNATURE OF CORONER

77. SIGNATURE OF DISTRICT ATTORNEY

78. SIGNATURE OF COUNTY CLERK

79. SIGNATURE OF TOWNSHIP CLERK

80. SIGNATURE OF VILLAGE CLERK

81. SIGNATURE OF CITY CLERK

82. SIGNATURE OF STATE CLERK

83. SIGNATURE OF FEDERAL CLERK

84. SIGNATURE OF MARSHAL

85. SIGNATURE OF SHERIFF

86. SIGNATURE OF CORONER

RECEIVED

BUREAU V. S.

JUN 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66697

CERTIFICATE OF DEATH

Reg. Dist. No. 353

6719

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Ocean City				c. LENGTH OF STAY IN 1b 25 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Old State Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Allen Last Dennis				4. DATE OF DEATH Month 6 Day 10 Year 19 56			
5. SEX Female	6. COLOR OR RACE A.A.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1893		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Orangeburg, South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Will Jenkins				14. MOTHER'S MAIDEN NAME Emma Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Martha Camper, West Ocean City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-1-53 to 6-10-56 , that I last saw the deceased alive on 6-9-56 , 19 56 , and that death occurred at 3:15 M, from the causes and on the date stated above. Clifford E. Schott ADDRESS (Street, city or town, state) Berlin Md. DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-17-56		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Worcester Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart ADDRESS Mary A. Stewart				24a. REC'D BY REGISTRAR 7/18/56		24b. REGISTRAR'S SIGNATURE Helen S. Hayward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66698

6720

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop RFD		c. LENGTH OF STAY IN 1b 18 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXXX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop RFD	
3. NAME OF DECEASED (Type or print) William H. Griffin		4. DATE OF DEATH June 6 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 17, 1881
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Edward H. Griffin		14. MOTHER'S MAIDEN NAME Harriet Bowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-36-2011	
17. INFORMANT Edw. Griffin		Address Selbyville, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular - accident sec.</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive - Cardio-vascular renal disease</u> 10 yrs (c) <u>Senile arteriosclerosis</u> 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cataract - Bilateral cataract operation R eye</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19 1956, to June 6, 1956, that I last saw the deceased alive on June 6, 1956, and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herman A. Raden M.D.		ADDRESS (Street, city or town, state) Bay St. Benlar, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/56	
22c. NAME OF CEMETERY OR CREMATORY I. O. O. F.		22d. LOCATION (City, town, or county) (State) Bishopville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley		ADDRESS Selbyville Del	
24a. REC'D BY REGISTRAR DATE 6-11-56		24b. REGISTRAR'S SIGNATURE Ray Bergen	

BUREAU V. S.

JUN 12 1956

RECEIVED

6721

CERTIFICATE OF DEATH

Reg. Dist. No. 255

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin				c. LENGTH OF STAY IN 1b Most of life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Flower Street				d. STREET ADDRESS Flower Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Axley Last Henry				4. DATE OF DEATH Month 6 Day 6 Year 19 56			
5. SEX Female		6. COLOR OR RACE A.A.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/9/1890	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Berlin, Worcester Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Middleton Briddell				14. MOTHER'S MAIDEN NAME Emma Dennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Frank Henry, Flower St., Berlin, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular disease DUE TO (c) Stroke Interval between onset and death 26 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/5 , 19 56 , to 6/6 , 19 56 , that I last saw the deceased alive on 6/6 , 19 56 , and that death occurred at 4:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Berlin, Md. DATE SIGNED 6/11/56							
ACTUAL SIGNATURE Harry H. Sully, Jr. M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-56		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Worcester Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart ADDRESS Mary A. Stewart J. F. Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR DATE 6-19-56		24b. REGISTRAR'S SIGNATURE Helen P. Hayward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66700

6722

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Worcester b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. # 1 (St Luke)				d. STREET ADDRESS R.D. # 1 (St Luke)			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE PURNELL LAYFIELD				4. DATE OF DEATH Month Day Year June 11 th 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1885		9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min. 5 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland (Somerset Co.)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Layfield				14. MOTHER'S MAIDEN NAME Henrietta Causey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lillian M. Layfield (Wife) R.D. # 1 St Luke Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 min.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1946, to 6-11-56, 19, that I last saw the deceased alive on 6-11-56, 19, and that death occurred at 11:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Lee L. Lawry M.D.							
PHYSICIAN'S NAME (Type) Dr. Lee Lawry M.D. Fruitland, Maryland June 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Smullen Cemetery		22d. LOCATION (City, town, or county) (State) R.D. # (St. Luke) Worcester Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 6-14-56		24b. REGISTRAR'S SIGNATURE May W. Hollaway	

BUREAU K. J.

NOV 31 1951

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6715

CERTIFICATE OF DEATH

66701

Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY Worcester Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke		c. LENGTH OF STAY IN 1b 61 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walnut St. cor 4th				d. STREET ADDRESS Walnut St. cor 4th		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL E. McMASTER				4. DATE OF DEATH Month Day Year June 16, 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 1, 1865		9. AGE (In years last birthday) yrs. 90	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Repair		11. BIRTHPLACE (State or foreign country) Libertytown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel McMaster				14. MOTHER'S MAIDEN NAME Mary Magdaline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Address Mrs. Susan L. McMaster, Pocomoke, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH 2 weeks years years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 21, 19 49</u> , to <u>June 16, 19 56</u> , that I last saw the deceased alive on <u>June 16, 19 56</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles W. Trader</u> M.D.				ADDRESS (Street, city or town, state) <u>Market St, Pocomoke, Md.</u>		DATE SIGNED <u>6-18-56</u>	
PHYSICIAN'S NAME (Type) Charles W. Trader				Pocomoke, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18/56		22c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry D. Watson</u>				ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR DATE <u>6-20-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Anne White</u>			

2

CERTIFICATE OF DEATH

8755

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH JUN 20 1956	
AGE 65		SEX Male	
RACE White		EDUCATION High School	
BIRTH DATE JUN 10 1891		BIRTH PLACE BALTIMORE, MARYLAND	
MARRIAGE DATE JUN 10 1915		MARRIAGE PLACE BALTIMORE, MARYLAND	
DECEASED'S RESIDENCE 1234 E. BALTIMORE AVE., BALTIMORE, MARYLAND		DECEASED'S OCCUPATION Retired	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED'S NEAREST RELATIVE JAMES H. HARRIS		SIGNATURE OF DECEASED'S PHYSICIAN JAMES H. HARRIS	
DATE OF SIGNATURE JUN 20 1956		DATE OF SIGNATURE JUN 20 1956	

BUREAU V. S.

JUN 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6723

CERTIFICATE OF DEATH

Reg. Dist. No.

06702
351

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. LENGTH OF STAY IN 1b Most of life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		d. STREET ADDRESS 205 Collins Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - 205 Collins Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Parker		4. DATE OF DEATH Month Day Year 6 - 4 - 1956	
5. SEX Male	6. COLOR OR RACE A.A.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Court House	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Parker		14. MOTHER'S MAIDEN NAME Emma Dale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-6214	
17. INFORMANT Address Mrs. Carrie Parker, 205 Collins St. Snow Hill, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardiac Disease (c) ?		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 22, 1956 , to June 5, 1956 , that I last saw the deceased alive on June 5, 1956 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas L. Jones, M.D.		DATE SIGNED June 5, 1956	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-56	
22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) Snow Hill, Worcester Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart		24a. REC'D BY REGISTRAR DATE JUN 7 1956	
ADDRESS Mary A. Stewart		24b. REGISTRAR'S SIGNATURE Clayton Cooper	

CERTIFICATE OF DEATH

0753

NAME OF DECEASED JOHN J. JONES		DATE OF DEATH JUN 1 1956	
AGE 45		SEX M	
RACE W		BIRTHPLACE MD	
MARRIAGE M		EDUCATION H	
OCCUPATION C		CAUSE OF DEATH C	
PLACE OF DEATH H		MANNER OF DEATH N	
DATE OF BIRTH JUN 1 1911		DATE OF MARRIAGE JUN 1 1935	
DATE OF DEATH JUN 1 1956		DATE OF BURIAL JUN 1 1956	
PLACE OF BURIAL C		MANNER OF BURIAL N	
DATE OF INTERMENT JUN 1 1956		DATE OF CREMATION JUN 1 1956	
PLACE OF INTERMENT C		PLACE OF CREMATION C	
DATE OF EXAMINATION JUN 1 1956		DATE OF POSTMORTEM JUN 1 1956	
PLACE OF EXAMINATION C		PLACE OF POSTMORTEM C	
DATE OF AUTOPSY JUN 1 1956		DATE OF EXHIBIT JUN 1 1956	
PLACE OF AUTOPSY C		PLACE OF EXHIBIT C	
DATE OF EXHIBIT JUN 1 1956		DATE OF EXHIBIT JUN 1 1956	
PLACE OF EXHIBIT C		PLACE OF EXHIBIT C	
DATE OF EXHIBIT JUN 1 1956		DATE OF EXHIBIT JUN 1 1956	
PLACE OF EXHIBIT C		PLACE OF EXHIBIT C	

BUREAU V. S.

JUN 7 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06703

6724

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. #2 Box 303</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. #2 Box 303</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>Pocomoke City, Maryland</u>	
3. NAME OF DECEASED (Type or print) <u>Ann</u> First <u>Parnell</u> Middle Last		4. DATE OF DEATH <u>June 12</u> 19 <u>56</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR: Months <u>12</u> Days <u>19</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Teagle</u>		14. MOTHER'S MAIDEN NAME <u>Louise Holden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-07-0506</u>	
17. INFORMANT <u>Hebert W. Purnell, R#2, Pocomoke</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Hypertensive Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>4 years</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Electrolyte Imbalance</u> <u>1 week</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/6</u> , 19 <u>55</u> , to <u>6/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/5</u> , 19 <u>56</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cecil A. Duverney</u>		DATE SIGNED <u>6/14/56</u>	
PHYSICIAN'S NAME (Type) <u>CECIL A. DUVERNEY, M.D.</u>		ADDRESS (Street, city or town, state) <u>801 Fourth Street, Pocomoke City, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar A. White - New Church</u>		24a. REC'D BY REGISTRAR DATE <u>6/18/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Anne E. White</u>			

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME

CAUSE OF DEATH

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DECEASED

DATE OF DEATH

TIME

CAUSE OF DEATH

BUREAU V. S.

JUN 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 353

1. PLACE OF DEATH: 6725		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Worcester	MARYLAND	STATE Maryland	COUNTY Worcester
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Bishop	LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Bishop, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 1170	
3. NAME OF DECEASED: (Type or Print) Everett L. Selby		4. DATE OF DEATH June 5 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, or SEPARATED: Married	8. DATE OF BIRTH: July 28, 1910
9. AGE last birthday: 45 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY: Own farm	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Sampson Selby		14. MOTHER'S MAIDEN NAME: Elsie Tubbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 222-10-5939	
		17. INFORMANT & ADDRESS: Edna Selby Bishop, Md.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) Shock of fracture, Cervical spine, +	DUE TO	Instantaneous
Antecedent cause(s) (b) Cerebral Cancer, Multiple	DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) An Fusion + Abrasion		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) 1170	21c. (City or town) (County) (State) St. Matthews, Worcester Co. Md.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 6/5/56 P.M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Acc. deer Automobile

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: Kenneth G. Radwin		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/7/56 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF: 6/8/56	NAME OF CEMETERY OR CREMATORY: L.O.O.F.	LOCATION (City, town, or county) (State): Bishopville Md.
DATE REC'D BY LOCAL REG. 6-8-56	REGISTRAR'S SIGNATURE: Gilda B. Bergoy	24. FUNERAL DIRECTOR: L. L. Selby Bishopville Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MINISTRY OF HEALTH & PUBLIC AFFAIRS
MALAYSIAN STATE DEPARTMENT OF HEALTH - KUALA LUMPUR

RECEIVED

Form with multiple sections and fields, mostly illegible due to fading. Visible text includes:

- NAME: [illegible]
- DATE: [illegible]
- ADDRESS: [illegible]
- TELEPHONE: [illegible]
- SEX: [illegible]
- AGE: [illegible]
- RELIGION: [illegible]
- EDUCATION: [illegible]
- PROFESSION: [illegible]
- REMARKS: [illegible]

BUREAU V. 1

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G199 7-9-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

067950

6716

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Belden Restorium		d. STREET ADDRESS Route # 2 Belden Restorium	
3. NAME OF DECEASED (Type or print) First Lizzie Middle J. Last Tull		4. DATE OF DEATH Month June Day 22 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1869
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Jester		14. MOTHER'S MAIDEN NAME Mary J. Matthews	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Joshua Hall, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) Hypertensive C-V + Valvular Disease		INTERVAL BETWEEN ONSET AND DEATH 2 days Same degree for approx. 2 years. 10 yrs. or more	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Paget's Disease, severe ② Fracture Hip Rt. (Dec 1, 1953)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 6, 1946 , to June 22, 1956 , that I last saw the deceased alive on 22 June, 1956 , and that death occurred at 7:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE N.E. Sartorius, Jr. M.D.		ADDRESS (Street, city or town, state) Pocomoke, Md	
PHYSICIAN'S NAME (Type) N. E. Sartorius, Jr. M.D.		DATE SIGNED Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-56	
22c. NAME OF CEMETERY OR CREMATORY Salem M.E. Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		ADDRESS Pocomoke, Md.	
24a. REC'D BY REGISTRAR June 28 1956		24b. REGISTRAR'S SIGNATURE Anne White	

RECEIVED

JUN 28 1956

BUREAU V. I.

MARRY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED: Mary Ann	
2. SEX: Female	
3. AGE: 5 years	
4. DATE OF BIRTH: 1-1-51	
5. PLACE OF BIRTH: Baltimore, Md	
6. RACE: White	
7. RELIGION: Catholic	
8. OCCUPATION: None	
9. CAUSE OF DEATH: Sudden	
10. PLACE OF DEATH: Home	
11. TIME OF DEATH: 10:00 AM	
12. SIGNATURE OF DECEASED: Mary Ann	
13. SIGNATURE OF WITNESSES: Mary Ann	
14. SIGNATURE OF PHYSICIAN: Mary Ann	
15. SIGNATURE OF CORONER: Mary Ann	
16. SIGNATURE OF JURY: Mary Ann	
17. SIGNATURE OF JUDGE: Mary Ann	
18. SIGNATURE OF CLERK: Mary Ann	
19. SIGNATURE OF NOTARY: Mary Ann	
20. SIGNATURE OF DECEASED: Mary Ann	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06706

6717

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>Home</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James W. Wise</u>				4. DATE OF DEATH Month Day Year <u>June 20 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1956</u>		9. AGE (In years last birthday) yrs. <u>29</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willard Wise</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Townsend, Pocomoke City, Md.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Willard Wise</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> <u>764.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Enteritis & Vomiting + Dehydration - Severe</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>56</u> , to <u>6/20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/20</u> , 19 <u>56</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald F. Fletcher</u>				ADDRESS (Street, city or town, state) <u>Norsey Va</u>		DATE SIGNED <u>6/21/56</u>	
PHYSICIAN'S NAME (Type) <u>Donald F. Fletcher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wardtown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>6/25/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Anne E. White</u>			

4000335 XV5

CERTIFICATE OF DEATH

Decedent's Name

Decedent's Name

Decedent's Name

Decedent's Name

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